Received _____

Approved _____

License No. _____

Issued _____

STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

APPLICATION FOR LICENSE AS A MEDICAL UTILIZATION REVIEW ENTITY

Application is hereby made on behalf of the medical utilization review entity herein named for a license authorizing it to transact business and to otherwise perform as a medical utilization review entity in New Hampshire.

1. The EXACT name of the medical utilization review entity is: _____

   _____

   (If the name is not in English, state it and give an exact literal translation.)

2. The medical utilization review entity's Federal ID number or Social Security number is: _____

3. This application is for (check one):

   _____ A new license.

   _____ Renewal of an existing license.

4. The applicant's current street address is:

   _____

   _____

   _____

5. The applicant's current mailing address is:

   _____

   _____

   _____

6. The applicant is a (check one):

_____ Sole Proprietorship

_____ Partnership

_____ Corporation

_____ Other (please specify) _____

a. If the applicant is a corporation, please specify the State of incorporation: _____

b. List all states in which the corporation does business:

_____

_____

_____

_____

_____

_____

7. List the principal proprietors, partners, directors, officers and administrators. Also, include any others responsible for the operation, management and control of the applicant. Attach a separate sheet of paper, if necessary.

Name(s) Title(s)

_____

_____

_____

_____

_____

_____

_____

_____

8. Attach separate sheets of paper giving biographical sketches of all persons listed under question 7. Include, at least, the person's current home address, current position(s), education and previous experience.

9. The applicant has _____ employees in New Hampshire and _____ employees nationally.

10. Locations. List all locations from which operations are conducted whether in or outside of New Hampshire. Show the range of activities and the number of employees at each location. Attach a separate sheet if necessary.

Location (City and State)	Activities	No. of Employees

11. Describe the types of medical utilization review programs offered by the applicant, including but not limited to:

    a. Second opinion program;
    b. Hospital preadmission review;
    c. Pre-inpatient service eligibility certification and
    d. Concurrent hospital review to determine appropriate length of stay.

    IT IS REQUESTED THAT THE APPLICANT PROVIDE THE INFORMATION REQUESTED BY ITEM 11 ON SEPARATE SHEETS OF PAPER ATTACHED TO THE APPLICATION FORM.

12. Describe the process by which the applicant proposes to perform each of the utilization review services listed under (11) above. Specify (1) The steps followed by the applicant's personnel as they perform each type of review program; and (2) the categories of health care personnel that perform medical utilization review for the applicant, and whether those persons are licensed in this or any other state.

    IT IS REQUESTED THAT THE APPLICANT PROVIDE THE INFORMATION REQUESTED BY ITEM 11 ON SEPARATE SHEETS OF PAPER ATTACHED TO THE APPLICATION FORM.

13. On separate sheets of paper attached to the application form, describe the process that the applicant will use to address beneficiary and provider complaints, requests for redeterminations and appeals.

14. The applicant is requested to enclose with the application copies of all materials used by the applicant to inform beneficiaries of the requirements of the utilization review plan and the rights and responsibilities of beneficiaries under the plan.

15. Has the applicant's utilization review program been certified by the Utilization Review Accreditation Commission (URAC)? Please check one.

Yes _____ No _____

Note: The applicant is requested to attach a copy of the accreditation certificate received from URAC.

16. List the telephone number(s), including toll-free numbers and fax numbers, at which beneficiaries and providers may reach representatives of the applicant. For each number listed indicate the number of lines maintained and the hours and days of the week during which the number is available.

Phone Number	Number of Lines	Days and Hours Available

16.a. Indicate the hours or days of the week during which calls are unanswered or answered solely by the recordings or answering services that do not provide access to representatives during the call.

_____

_____

_____

_____

17. The applicant is requested to attach separate sheets of paper describing the procedures established by the applicant for preserving the confidentiality of medical information used in the utilization review process.

18. I have read the foregoing application and attachments and state that the answers supplied therein are true and correct to the best of my knowledge and belief. The undersigned also acknowledges that all applicable state and federal laws to protect the confidentiality of medical information will be followed. Further, by submitting this application to the Insurance Department, the applicant acknowledges that it has read and will comply with the performance standards set forth in RSA 420-E and any applicable rules.

Signed on behalf of the applicant by:

_____

Name (Typed) _____

Title: _____

Date: _____

f:michele/urapplication.doc